REQUEST FOR PROPOSALS

To Contract As a

Managed Care Organization

for the delivery of

Managed Long-Term Care in Selected Service Areas

RFP # 1568-DDES-SM

August 14, 2006

Wisconsin Department of Health and Family Services

RFP TIMELINE

Monday, August 14, 2006	**Release of RFP**
August, 23, 2006 deadline for providing	**Provide Notice of Participation in Proposers' Conference Call**
Friday, August 25, 2006	**Proposers' conference call**
Friday, September 1, 2006	**Publish answers to all submitted questions**
Friday, September 22, 2006 (no later than 4:00 p.m.)	**Due date for proposals**
Friday, October 6, 2006	**Oral interviews, if necessary**
Friday, October 13, 2006	**Announcement of intent to award**
Friday, October 27, 2006	**Public announcement of awards**
Friday, December 15, 2006	**Completion of MCO certification**
Monday, January 1, 2007	**Proposed effective date of contract**

SECTION 1: REQUEST FOR PROPOSALS (RFP) PURPOSE AND BACKGROUND

1.1 Purpose

The Department of Health and Family Services (DHFS) is requesting proposals from entities seeking certification by the Department to contract as managed care organizations for the delivery of managed long-term care to elders and adults with disabilities in specific service areas.

This solicitation is Part 1 of a three-part process that will culminate in contracts for delivery of managed long-term care. To be offered a contract through this three-part process, an entity must

Part 1: Demonstrate through its response to this RFP that it possesses or has capacity to secure sufficient resources to meet certification standards for managed long-term care organizations (see Appendix 1 – Readiness Template).

Part 2: Achieve certification as a managed long-term care organization by meeting DHFS certification standards.

Part 3: Contract with DHFS to deliver specific managed long-term care benefits (see Section 1.4.5) to specific target groups (see Section 1.4.4) in a designated service area (see Section 1.4.3). The decision to offer a contract is at the sole discretion of DHFS and will be based on the relative merits of proposers' responses to this RFP as evaluated by an evaluation committee selected by DHFS and during the subsequent certification process.

1.2 What is managed long-term care?

Managed long-term care is delivery of a defined benefit package (see Section 1.4.5) under a risk-based capitated contract to eligible elders and adults with disabilities who need long-term care services and meet the eligibility requirements for state-funded managed long-term care (see Appendix 2 – Eligibility for Managed Long-Term Care).

1.3 What is the purpose of managed long-term care?

Managed long-term care, pioneered in Wisconsin by Family Care and the Wisconsin Partnership Program, is an innovative way of delivering long-term care services. These programs were designed with the input of consumers, advocates, providers, state and local officials, and others in order to address concerns about the cost and complexity of the multiple long-term care programs and services available, inequities in availability of community and institutional services, and projections for an aging population's growing demand for long-term care. Managed long-term care is intended to provide cost-effective, comprehensive and flexible long-term care that fosters consumers' independence and quality of life, while recognizing the need for interdependence and support, with the specific goals of:

- Giving more people choices about where they live and what kinds of services and supports they receive to meet their long-term care needs;

- Improving access to long-term care services;

- Improving quality through a focus on health and social outcomes; and

- Creating a cost-effective long-term care system for the future.

Managed long-term care in Wisconsin has two major organizational components:

Aging and disability resource centers are designed to be the single recognized source for older people and people with disabilities and their families to get information and advice about a wide range of resources available to them in their local communities, including long-term care services and managed long-term care. The Department will contract for managed long-term care only in areas that are served by an aging and disability resource center. Resource centers provide:

- Information and assistance

- Long-term care options counseling

- Benefits counseling

- Emergency response

- Prevention and early intervention

- Facilitation of eligibility and enrollment in managed long-term care for applicants, including:

    - Determining functional eligibility using a standardized functional screening tool;
    - Arranging with economic support for financial eligibility determination;
    - Arranging for applicants to meet with the state-contracted independent enrollment; consultant to discuss whether managed long-term care is their best option; and
    - Arranging for eligible applicants who choose managed long-term care to enroll in the managed care organization for receipt of the managed long-term care benefit.

Managed care organizations (MCOs) manage and deliver the managed long-term care benefit (see Section 1.4.5), which combines funding and services from a variety of existing programs into one flexible benefit. From the benefit, the MCO weaves together a package of services and supports that is tailored to each individual's needs, circumstances and preferences. MCOs:

- Develop a comprehensive network of providers of long-term care and health care services in the managed long-term care benefit package;

- Accept prepaid capitated payments to provide all of the services in the benefit package that each individual enrollee needs;

- Provide services and supports in the benefit package for each enrollee in accordance with a comprehensive assessment of the individual's needs, preferred outcomes and service preferences, and an individualized service plan designed by the enrollee and an interdisciplinary team to support those needs, preferences and outcomes;

- Provide ongoing care management to protect the health and well-being of enrollees and to support enrollees in achieving their desired personal-experience outcomes, which are:

    - I decide where and with whom I live
    - I make decisions regarding my supports and services
    - I decide how I spend my day
    - I have relationships with family and friends I care about
    - I do things that are important to me
    - I am involved in my community
    - My life is stable
    - I am respected and treated fairly
    - I have privacy
    - I have the best possible health
    - I feel safe
    - I am free from abuse and neglect

- Assure and continually improve the quality of care and services that members receive.

1.4 Overview of DHFS intent for this RFP

1.4.1 Who is eligible to receive the managed long-term care benefit from an MCO?

To receive the managed long-term care benefit, an individual must be aged 18 or over, and

- Be a member of one or more of the following target groups:
    - People who are frail elderly
    - People with developmental disabilities
    - People with physically disabilities

- Meet level of care (functional eligibility) and financial eligibility requirements (see Appendix 2 – Eligibility for Managed Long-Term Care); and

- Reside in an area served by the MCO.

1.4.2 Who may submit a proposal?

A proposer must be a legal entity that is legally able to enter into a risk-based contract in Wisconsin. A contract to deliver the managed long-term care benefit will be with a single entity that is responsible for all obligations specified in the contract.

Such entities include:

- A county under s. 2.01 Wisconsin Statutes (see Section 1.4.3 for more information);

- A group of counties acting cooperatively under s. 66.030 Wisconsin Statutes;

- A Family Care district as defined in s. 46.2895 Wisconsin Statutes;

- An HMO or similar organization regulated by the Office of the Commissioner of Insurance;
- A federally-recognized Wisconsin Indian Tribe; or
- A group of any of the above entities working under a contractual agreement

A contract for delivering managed long-term care will be between DHFS and a single entity which takes on responsibility for complying in all ways with the contract, and assumes responsibility for any risk.

1.4.3 What service areas may a proposal include?

The Department's long-term goal is to expand managed long-term care statewide. In this RFP, the Department is limited to contracting in areas that represent, overall, no more than half of the state's population, including the counties where the Family Care and Partnership programs are presently operating.

Proposals will be accepted from entities seeking to operate an MCO to provide the managed long-term care benefit in the following service areas in Wisconsin:

- Kenosha and Racine counties

This RFP will result in identification of organizations with which the Department may contract to ensure that a managed long-term care benefit is available to all eligible individuals in these service areas. Proposals for MCOs that will serve an entire service area are strongly preferred. DHFS reserves the right to reject any proposal that will not serve the entire service area.

Consideration will be given to proposals that phase in services to various geographic sectors of the service area over a period of not more than 24 months after the contract effective date.

Contractors will be required to develop a plan jointly with DHFS to manage enrollment into the MCO so that by 24 months after the initial contract date, the MCO has the capacity to enroll every eligible person who chooses to enroll.

1.4.4 What persons and target populations may a proposal include?

For purposes of this RFP, managed long-term care target groups are limited to people who are elderly and adults with developmental and/or physical disabilities. The Department intends to ensure that enrollment in a managed care organization is equally available to individuals from all three of these target groups. Therefore, proposers that will seek certification as MCOs that will serve all target groups are strongly preferred. However, a proposal to phase in services to the specified target groups over a period of not more than 12 months after the contract effective date will be given consideration. The Department reserves the right to reject any proposal for an MCO that will not serve all target groups.

1.4.5 What is the managed long-term care benefit package?

1.4.5.1 Family Care as the minimal benefit package

Every proposer must plan to offer at least the Family Care benefit (see http://dhfs.wisconsin.gov/LTCare/Generalinfo/Benpackage.htm). Where it is feasible, we are also open to proposals that go beyond Family Care by incorporating acute and primary care into a benefit package along with long-term care. For more information about benefit packages for the expansion of managed long-term care, see the paper titled "Managed Long-Term Care Expansion Planning Information #2" at http://dhfs.wisconsin.gov/ManagedLTC/grantees/pdf/info2benefitops.pdf

1.4.5.2 Wisconsin Partnership Program benefit package

Proposers may propose to expand the Family Care benefit in order to offer the Wisconsin Partnership Program benefit package that includes all of the services in the Family Care benefit and all other Medicaid services. For additional Medicaid service definitions see http://www.legis.state.wi.us/rsb/code/hfs/hfs107.pdf. The Wisconsin Partnership Program consists of a risk-based contract for the delivery of all Medicaid health and long-term care services and a risk-based contract directly with Medicare for the delivery of the Medicare Part A, Part B and Part D benefits. For DHFS to consider contracting with an entity to offer the Partnership Benefit, the proposer must provide evidence that it will have a risk-based contract directly with Medicare for the delivery of the Medicare Part A, Part B and Part D benefits in place by January 1, 2007.

1.4.5.3 Other benefit packages

DHFS will consider proposals for other combinations of services as long as the proposed benefit package includes all of the services in the Family Care benefit. Approval of an alternative benefit package is at the sole discretion of DHFS. If an alternative benefit package under this Section is approved, additional state statutory and/or federal authority may be required and additional changes to state reporting and payment systems may be necessary. Because of this, a proposal to deliver any other benefit package will likely delay the effective date as DHFS seeks authority and modifies systems.

1.4.6 Will DHFS contract with more than one entity in a service area?

DHFS may choose to contract with more than one entity to provide managed long-term care in any single geographic service area (see Section 1.4.3). DHFS must ensure that each organization with which it contracts has a sufficient number of potential enrollees within its service area to allow for its successful operation as a managed long-term care organization. A proposal must indicate the minimum number of enrollees it projects will be necessary to successfully deliver managed long-term care. If DHFS awards contracts to more than one proposer in a service area, it will negotiate enrollment capacity with each proposed contractor prior to certification and contracting. In single geographic areas in which DHFS contracts with more than one long-term care MCO, enrollees will have an opportunity to change MCO at least twice per year during "open enrollment periods," and may change at other times for cause with approval of the State.

1.4.7 What are the prerequisites to a contract?

DHFS may offer a contract to an organization to operate a managed care organization in a specified service area if:

- It determines through this RFP process that a proposer likely has or can secure sufficient resources to meet the standards for managed long-term care organizations

- The organization is certified by DHFS as meeting those standards

1.4.8 What is the duration of the contract?

DHFS will offer a contract for the duration of the calendar year in which the contract begins, with the option for annual one-year renewals, not to exceed five years in total, if the MCO continues to meet performance requirements. In order to coordinate RFPs across different service areas, DHFS may conduct a new RFP process prior to the end of the five year contract period.

1.4.9 Funding

1.4.9.1 Payments to MCOs

DHFS will provide an MCO with a capitated payment for each person who enrolls. Capitation rates are determined using an actuarially sound methodology for projecting the average per-person cost of services for persons entitled to the managed long-term care benefit. (See http://dhfs.wisconsin.gov/LTCare/StateFedReqs/CapitationRates.htm for more information on Family Care rates. For more information on Wisconsin Partnership Program capitation rates see http://dhfs.wisconsin.gov/WIpartnership/WhatsNew.htm. See also the webcast on Rates and Risk Reserves at http://dhfs.wisconsin.gov/ManagedLTC/grantees/webcasts/033006.htm.) If the case mix of persons actually enrolled by an individual MCO varies significantly from the case mix projected in rate setting, rates may be retroactively adjusted to reflect actual versus projected case mix.

1.4.9.2 Effect on other funding for long-term care

Funding for other long-term care programs operated by the county or counties in the service area (Community Options Program, COP-Waiver, CIP II, CIP IA, CIP IB, Brain Injury Waiver and other county long-term care programs funded by Community Aids) for persons in the managed long-term care target groups will be transferred to the managed long-term care benefit through an agreed upon implementation plan for an orderly implementation of managed long-term care, including a respectful transition of existing cases. At full implementation of managed long-term care, waiver services and other community-based long-term care services will be available only to persons who choose to enroll in managed long-term care. Other Medicaid services in the benefit package (see Section 1.4.5) will also be available through managed long-term care to persons who choose to enroll. For persons who choose not to enroll, Medicaid State Plan services (card services) will continue to be available from fee-for-service providers, pending any other state or federal decision that may modify this assumption at some time in the future.

SECTION 2: PROPOSAL

General Instructions

Proposers must submit their completed proposal electronically and in hard copy (see Section 3 for submission instructions.) The Department reserves the right to reject any proposal that is not complete. If an attachment is used to provide supporting information, number it with the number of the section or subsection to which the supporting information is applicable. For example, an organizational chart that is used to provide information in response to Section 2.1.4 must be labeled "Attachment 2.1.4". Evaluators may not consider attached information that is unlabeled or improperly labeled.

Name and contact information of proposer: Provide the name of the organization submitting the proposal and its mailing address. Provide the name, telephone number, fax number and e-mail address of the organization's principal contact person for this proposal. This information must be provided on form DOA 3477, (see attached forms).

Authorized signature: Signature of a person authorized to represent the proposer organization. This must be provided on form DOA 3261 (see attached forms).

2.1 Proposer Information (100 points)

2.1.1 Organization authority to enter into a risk-based contract

Describe the statutory authority under which the proposer organization was created and is able to enter into a risk-based contract (see Section 1.4.2).

2.1.2 Description of proposer organization

2.1.2.1 Governance and organizational structure

Describe the governance structure of the proposer organization, identifying lines of authority and operating responsibility.

2.1.2.2 Contractual relationships

Describe any relationships between the proposer organization and any other entities with which it has relationships specific to the purpose of contracting for the delivery of the managed long-term care benefit specified in Section 2.2.3. Include a description of the relationship between the proposer and every participating entity in the proposer organization.

Describe how the MCO will meet Wisconsin statutory requirements for a Family Care governing board, s.46.285(6), Wis. Stats., including having membership that reflects the ethnic and economic diversity of the geographic area served by the MCO, and having at least one-fourth of the members being older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the MCO's proposed enrollment.

2.1.3 Relationships with other organizations

Describe any affiliation between the provider and any other entity that provides health care or long term care services, not specific to the purpose of contracting for the delivery of the managed long-term care benefit specified in Section 2.2.3, that may affect the operations or administrative decisions of the proposer organization.

2.2 Scope of proposal (100 points)

2.2.1 Geographic service area

Describe the geographic area in which the proposer intends to contract to provide managed long-term care. The proposer must demonstrate that the proposed service area has sufficient population so that the number of potential enrollees is able to support the proposer's business plan (see Section 2.3.6). Generally, an MCO that expects its enrollment will not reach 1,500 members will not be considered; however, this minimum may be waived in exceptional circumstances at the request of a proposer and at the sole discretion of DHFS. A service area, generally, may not include partial county areas; however, this requirement may be waived in exceptional circumstances at the request of a proposer and at the sole discretion of DHFS.

2.2.2 Target populations

A proposal must be to serve frail elders, and adults with physical or developmental disabilities (see Section 1.4.4). This requirement may be waived at the request of a proposer and at the sole discretion of DHFS if the Department's goal of serving all target groups can be met through contracting with multiple organizations to deliver the managed long-term care benefit. List the target groups proposed to be served and the timeline for serving each. Target groups to be served may be phased in over the initial 12 months of operation.

2.2.3 Managed long-term care benefit package

Every proposal must be to provide at least the services in the Family Care benefit but may expand that benefit to incorporate acute and primary care into a benefit package along with long-term care (see Section 1.4.5.). Specify the proposed benefit package(s).

2.2.4 Other services or benefits provided by the proposer

Identify any other health care services, benefits or plans that are offered by the proposer, or that the proposer anticipates offering in the future. These could include SSI managed care, Medicaid managed care for children and families, a Medicare special needs program, a Medicare prescription drug plan, a Medicare Advantage plan or any other health care service or plan, or the Program for All-Inclusive Care for Elders (PACE). (Note: For DHFS to consider contracting with an entity to offer the Partnership benefit, the proposer must provide evidence that it will have a risk-based contract directly with Medicare for the delivery of the Medicare Part A, Part B and Part D benefits in place by January 1, 2007.)

2.3 Organizational capacity to implement managed long-term care (600 points)

Points for this section are further subdivided as follows:

- Section 2.3.1: Stability and public accountability (200 points)
- Section 2.3.2: Community based experience (200 points)
- Section 2.3.3: Managed care capacity (200 points)

In this section, the proposer is asked to demonstrate that it possesses, or how it will acquire, the skills and resources needed to successfully deliver managed long-term care. This section is an initial evaluation of the proposer's potential to meet the standards necessary for DHFS to certify, prior to entering into a contract, that the organization has the capacity to deliver the managed long-term care benefit specified in Section 2.2.3. If DHFS determines that a proposer likely has the potential to meet the necessary standards, the organization will then be required to meet certification requirements prior to entering into a contract.

Between notification that DHFS has determined that a proposer likely has the potential to meet the necessary standards and the effective date of contracting, a proposer will be expected to plan for implementation of the managed care organization and secure the resources needed for meeting certification, including:

- Developing needed business systems and information technology;
- Planning with aging and disability resource center(s) and income maintenance unit(s) to ensure efficient procedures for enrollment of persons determined eligible and who want to enroll;
- Planning with current long-term care program(s) and providers and with individual enrollees to ensure a smooth transition of responsibility and service provision to the new organization;
- Developing needed provider contracts to ensure provider network adequacy and capacity;
- Developing management and staff capacity, including interdisciplinary team capacity, to provide services immediately upon enrollment to any eligible person who applies; and
- Any other activities needed for certification by DHFS.

No later than 45 days prior to the entering into a managed long-term care contract the proposer will be expected to meet all certification requirements (see Appendix 1 – Readiness Template).

On the effective date of the contract, the managed care organization will be expected to:

- Have completed all planning and resource development activities, and have in place the systems, resources and procedures needed to deliver the managed long-term care benefit specified in Section 2.2.3.

- Have the capacity to carry out an enrollment plan developed jointly with DHFS that will result, within a specified timeframe, agreed upon by the parties, in the MCO being able to enroll, with no waiting, all persons who are eligible.

2.3.1 Stability and public accountability

Competitive procurement rules required by the federal government allow private entities, as well as public entities, to compete to deliver publicly-funded managed long-term care benefits. The State procurement and certification processes will result in contracts with organizations that can be depended upon to remain in business and continue to deliver services over a long period of time. Under such contracts, MCOs are accountable for the health and safety of the individuals they serve, for the delivery of quality services and are responsive to long-term care consumers within the proposed service area.

2.3.1.1 Stability

Provide evidence that the proposer can be depended upon to remain in business and continue to deliver services over a long period of time. Include information about the history of the organization and its founding or partnering organizations. Provide evidence of commitment to the proposer organization's mission and ongoing operation by its governing board and any founding or partnering organizations. This evidence should describe how the MCO governing board will be compliant with statutory requirements for Family Care MCO governing boards, found in s.46.285(6), Wis. Stats.

2.3.1.2 Accountability

Identify the mechanisms by which the proposer is accountable to and responsive to persons who receive its services and the public at large.

2.3.2 Experience in delivery of community-based long-term care services

Managed long-term care emphasizes providing long-term care services to people where they choose to live. When people choose to reside in nursing facilities or ICFs-MR, those facilities are responsible for the care and treatment of those individuals, and for addressing health and safety needs. When individuals with health and long-term care needs choose to live in their own homes or other community-based settings, the MCO is responsible for developing a care plan that addresses their care and treatment needs, and provides assurances for health and safety.

2.3.2.1 Organizational expertise

Identify experience the proposer has in delivering community-based long-term care, including comprehensive assessments of those individuals and what they need to live successfully in community-based settings, and in providing services and supports to enable people to do so safely.

2.3.2.2 Organizational experience in individualizing services in managed care

The Department seeks to contract with MCOs that are person-centered and outcome-focused. This requires the ability to work with members to identify the real life results, or outcomes, they want to achieve through their health and long-term care services and supports, and keeping the member at the center of the care management team developing the care plan and determining what services and supports to put in place. Identify the expertise the proposer has in delivering individualized services under a managed care contract.

2.3.2.3 Acquiring qualified interdisciplinary care management team staff

Care management is the core function of the managed long-term care organization. Describe the proposer's plan to obtain qualified clinical care management staff necessary to deliver the managed long-term care benefit specified in Section 2.2.3 to the membership projected in the initial business plan (see Section 2.3.6). This includes having specialized knowledge of the conditions of the target populations served by the MCO, a knowledge of community alternatives for those target populations, and knowledge of the full range of long-term care resources.

2.3.2.4 Interdisciplinary care management team staff training

Identify the proposer's plan for training interdisciplinary care management staff in:

- Identifying outcomes;
- Person-centered planning;
- The State's resource allocation decision-making methodology (RAD);
- Supporting opportunities for self-direction and self-directed supports;
- Functional limitations and service needs of the managed long-term care target groups;
- The range and availability of community-based long-term care services and supports;
- Dealing with mental health and substance abuse among the long-term care target groups.

2.3.3 Organizational capability for managed care

Managed long-term care requires experience in capitated risk-based contracting.

2.3.3.1 Organizational experience in managed care

Describe the proposer's experience in managed long-term care in each of the business areas identified in Appendix 1 – Readiness Template.

2.3.3.2 Acquiring qualified business management staff

Describe the proposer's plan to obtain staff and other resources to ensure it has the business systems and quality management systems necessary for successful operation of a managed long-term care organization, including:

- Strategic planning;
- Provider network management;
- Budgeting, accounting and financial management;
- Information management;
- Claims processing;
- Quality management; and
- Executive and supervisory staff to support the care management function.

2.3.3.3 Provider network

The provider network is one measure of a proposer's ability to meet the needs of its members. Prior to entering into a managed long-term care contract a proposer will have to have a provider network that DHFS has certified is adequate. Provide evidence that the proposer has a workable plan and the resources to, by the time the contract is entered into, build a comprehensive network of providers with the capacity to deliver the proposed managed long-term care benefit specified in Section 2.2.3 to the membership projected in the initial business plan (see Section 2.3.6).

2.3.3.4 Solvency and risk

An MCO will be required to have cash reserves that are sufficient to:

- Assure that the organization has adequate cash flow to hire staff and subcontract with providers that will be necessary to deliver the proposed benefit specified in Section 2.2.3;
- Allow the organization to manage fluctuation in enrollment, capitation payments and other receipts and fluctuation in the cost of delivering services in the benefit package based on individual needs of enrollees;

- Ensure that the organization has sufficient reserves to continue to meet the individual needs of enrollees for a minimum of three months in the event that the managed long-term care contract is terminated by DHFS or by the managed long-term care contractor; and

- Assure that the organization has a reasonable expectation of ongoing solvency.

In meeting these requirements, a proposer can anticipate that:

- Any organization that specifies in Section 2.2.3 that it intends to provide a benefit package that includes primary and/or acute health care services will be required to be licensed as an HMO or other insurance entity by the Office of the Commissioner of Insurance;

- Any organization other than a county or group of counties acting jointly but retaining individual risk will also be required to be licensed as an HMO or other insurance entity by the Office of the Commissioner of Insurance;

- A county or group of counties acting together to contract to deliver the Family Care benefit will be required to meet cash reserve, risk reserve and solvency reserve requirements as specified in the Family Care contract (see http://dhfs.wisconsin.gov/LTCare/StateFedReqs/CY06CMOContract.pdf) A county or group of counties contracting to provide the Family Care benefit will need to have a plan to reach all solvency requirements within three years of the date of the initial contract.

Provide evidence that the proposer will have adequate cash flow, risk reserves and solvency protection consistent with the points outlined immediately above, for the delivery of the managed long-term care benefit proposed in Section 2.2.3.

2.3.3.5 Business plan

Submit an initial business plan that projects that, if awarded a managed long-term care contract, the proposer will be financially stable within two years of initial contract award, and remain financially stable following that. For purposes of this RFP process the initial business plan should at minimum identify:

- Projected enrollment

- Anticipated capitation rate required to provide the benefit package specified in Section 2.2.3

- Any other anticipated revenue

- Projected staffing costs for:
  - Management and administrative staff
  - Interdisciplinary team staff to serve anticipated growth in enrollment
  - Other internal staff

- Projected cost of purchased services and supports

- Projected cost of any risk sharing, reinsurance or stop-loss insurance

- The source and amount of any cash, risk or solvency reserves
- Cash flow in relation to anticipated revenues and expenditures including any projected costs of building or maintaining reserves

2.4 Coordination with outreach and access services (50 points)

2.4.1 Aging and disability resource centers

Provide evidence that any aging and disability resource centers within the proposed service area have been informed of the proposer's intent to respond to this RFP. If there is currently no aging and disability resource center in the proposed service area or part of the service area, provide evidence that there is an organization ready and willing to apply to the Department to become an aging and disability resource center.

2.4 2 Eligibility and enrollment

Provide evidence that the income maintenance units in the counties within the proposed service area have been informed of the proposer's intent to respond to this RFP.

2.5 Coordination with related programs and services (50 points)

2.5.1 Existing community-based service programs

Provide evidence that the current COP / Waiver agency or agencies in the proposed service area have been informed of the proposer's intent to respond to this RFP.

2.5.2 Existing managed long-term care organizations

Provide evidence that any existing managed long-term care organizations already operating in the proposed service area have been informed of the proposer's intent to respond to this RFP. This includes MCOs serving the SSI population, the Medicaid long-term care population, and Medicare Special Needs Plans serving individuals also eligible for Medicaid and/or designated as an institutional Special Needs Plan.

2.5.3 Other related county-operated programs and services

Provide evidence that the following county agencies within the proposed service area have been informed of the proposer's intent to respond to this RFP.

- Adult protective services
- Public health services
- County aging units and agencies providing services to elders including congregate or home-delivered meals or other nutrition services, senior companionship, transportation services, etc.
- Alcohol and other drug abuse services

- Mental health services
- Children’s long-term care services
- Emergency food, shelter and energy assistance services
- Services to children and families

2.5.4 Other related regional programs and services

Provide evidence that regional agencies that provide other related services within the proposed service area have been informed of the proposer’s intent to respond to this RFP, including:

- Area Agencies on Aging
- Independent Living Centers
- Hospitals, clinics and other regional health care providers

2.6 Stakeholder involvement (100 points)

2.6.1 Efforts to involve stakeholders in proposal development

Provide evidence that consumers, advocates, service providers, aging and disability resource centers and other county human/social service agencies have been involved in the development of this proposal.

2.6.2 Plans for future efforts to involve stakeholders

Describe the proposer’s plan for soliciting input from consumers, advocates, service providers, aging and disability resource centers and other county human/social service agencies in the future.

SECTION 3: PROPOSAL SUBMISSION INSTRUCTIONS

3.1 Deadline for delivery

Complete submission materials must be received no later than 4:00 p.m. on September 22, 2006.

3.2 Place of delivery

Submission materials must be addressed to and received at:

MLTC Proposal
DDES / BLTS / Managed Care Section
1 W. Wilson St., Room 518
P.O. Box 7851
Madison, WI 53707-7851

3.3 Manner of delivery of Proposal Submission

Submission materials may be delivered in person or by US mail or other delivery service with signature confirmation of receipt. For proposals delivered postal or other delivery services, the signature confirmation will serve as proof of receipt. Proposals hand carried will be date stamped/marked at the time of receipt. Receipt of a proposal by the State mail system does not constitute receipt of a proposal by the named Office in Section 3.2 for purposes of this RFP. Proposers are cautioned to allow sufficient time for delivery by the U.S. Post Office because it can sometimes take several days to receive mail from outlying areas. Any proposals, which are received after the closing date and time, by the office named in Section 3.2 will not be reviewed and will be returned to the vendor. No exceptions will be allowed. Supplemental and clarifying information will not be accepted from a proposer after the deadline for submittal of proposals, unless requested by DDES.

3.4 General submission instructions

3.4.1 Completeness

The Department reserves the right to reject any proposal that is not complete.

3.4.2 Electronic document submission

Proposers must include within their hard copy proposal package a compact disc (CD) that contains:

1. An electronic copy of their proposal. Name the completed electronic document, "MLTC - [name of organization in Section 2.1.1]". For example, "MLTC - ABC Inc".

2. Electronic copies of any attachments (see Section 3.4.4) used to provide supporting information. Name electronic attachments using the following naming convention: "MLTC - [name of organization in Section 2.1.1] – attachment [section or subsection number to which the attachment is applicable]". For example, an organizational chart

that is used to provide information in response to Section 2.1.4 must be named, "MLTC - ABC Inc - attachment 2.1.4".

3.4.3 Hard copy submission

Proposers must submit a hard copy of:

1. Completed Section 2 with the signature in Section 2.1.2 of a person authorized to represent the proposer organization.

2. Copies of any attachments (see Section 3.4.4) used to provide supporting information. Label attachments at the top of the first page using the following naming convention: "MLTC - [name of organization in Section 2.1.1] - Attachment [section or subsection number to which the attachment is applicable]". For example, an organizational chart that is used to provide information in response to Section 2.1.4 must be labeled at the top of its first page, "MLTC - ABC Inc - Attachment 2.1.4".

3.4.4 Attachments

Attachments may be used to provide supporting information. Attachments may not exceed 25 pages in total. Evaluators will not be required to consider attached information that exceeds the maximum length or is unlabeled or improperly named.

3.4.5 Incurring costs

The State of Wisconsin is not liable for any cost incurred by proposers in replying to this RFP.

3.4.6 Withdrawal of proposals

Proposals shall be irrevocable until contract award unless the proposal is withdrawn. Proposers may withdraw a proposal in writing at any time up to the proposal closing date and time or upon expiration of 5 days after the due date and time if received by the RFP project manager. To accomplish this, the written request must be signed by an authorized representative of the proposer and submitted to the RFP project manager. If a previously submitted proposal is withdrawn before the proposal due date and time, the proposer may submit another proposal at any time up to the proposal closing date and time.

3.5 Method of Qualification

The Evaluation Committee's scoring will be tabulated according to the final points awarded for each proposal. Those proposals meeting the requirements of the RFP will move to the next phase. All vendors who respond to this RFP will be notified in writing whether they will qualify to move to the next phase.

The proposals will be scored using the following criteria:

1. Proposer information	100 points	(10%)
2. Scope of Proposal	100 points	(10%)
3. Organizational capacity	600 Points	(60%)
a. Stability and public accountability	(200 points 20%)	
b. Community based experience	(200 points 20%)	
c. Managed care capacity	(200 points 20%)	
4. Coordination with outreach and access	50 points	(5%)
5. Coordination w/ related services	50 points	(5%)
6. Stakeholder involvement	100 points	(10%)
Total:	1,000 points	(100%)

3.6 Standard terms and conditions

The State of Wisconsin reserves the right to incorporate standard State contract provisions into any future contract negotiated from any proposal submitted responding to this RFP who meets the qualifications to move on to Phase II of this RFP (Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681)). Failure of the successful proposer to accept these obligations in a contractual agreement may result in cancellation of the award.

3.7 General Proposal Information

3.7.1 VendorNet registration

The State of Wisconsin's purchasing information and vendor notification service is available to all businesses and organizations that want to sell to the state. Anyone may access VendorNet on the Internet at http://vendornet.state.wi.us to get information on state purchasing practices and policies, goods and services that the state buys, and tips on selling to the state. Vendors may use the same Web site address for inclusion on the bidders list for goods and services that the organization wants to sell to the state. A subscription with notification guarantees the organization will receive an e-mail message each time a state agency, including any campus of the University of Wisconsin System, posts a request for bid or a request for proposal in their designated commodity/service area(s) with an estimated value over $25,000. Organizations without Internet access receive paper copies in the mail. Increasingly, state agencies also are using VendorNet to post simplified bids valued at $25,000 or less. Vendors also may receive e-mail notices of these simplified bid opportunities

3.7.2 Proposers' Conference Call

A proposers' conference will be conducted via conference call from 1:00 – 3:00 p.m. on August 25, 2006. To participate, call one of the following numbers and then enter the passcode when cued to do so.

Number: 608-265-1000
Toll Free: 800-462-1257
Passcode: 2676#

In order to assure adequate lines are available for the call, notify the Department that you plan to participate in the call by the end of business on August 23, 2006. Notification should be made to:

Monica Deignan
608/261-7807
deignma@dhfs.state.wi.us

The Department will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations at the proposers' conference, contact Susan McKercher, Procurement Manager, at (608) 267-7637(voice), or e-mail: mckers@dhfs.state.wi.us

3.8.3 Required forms

DOA 3477 Vendor Information Sheet
DOA 3261

Attachments

DOA 3054 Standard Terms and Conditions
DOA 3681 Supplemental Standard Terms and Conditions

APPENDIX 1 – READINESS TEMPLATE

DDES Management Planning Tool For LTC Expansion "Readiness Template"

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)

Strategic Planning	The 3-year MCO business plan approved prior to contract effective date, including:
	– Timeline for providing required risk reserve, solvency requirements, and working capital (if not licensed as an HMO).
	
	Organizational design and governance:
	
	Existence of legal (contracting) entity that will carry the financial risk and be responsible for quality, including:
	– Governance board with membership able to provide appropriate oversight.
	– Organization chart w qualified and full-time CEO, CFO, and Quality Manager.
	
	Documentation of how MCO will coordinate with adult protective service and counties' 51/55 systems.
	
	Evidence of consumer and other stakeholder involvement in strategic planning.
		Establishment of a Risk Reserve and Business Solvency Plan, with timeline and financing strategy.
		
		Consumer and Stakeholder Participation:
		– Identify stakeholders and provide opportunities for consumers and stakeholders to participate in planning process.
		– Provide training/support to enhance meaningful consumer and stakeholder participation.
		– Create mechanisms for consumers and reps to participate in quality management and appeals and grievance processes.
		
		Develop policies and procedures for best practices (designing quality into the organization).
		
		Legal and Operational Platform for Regionalized Governance satisfactory to all planning partners, including:
		– Mission and values statements.
		– Operating and risk sharing agreements.
		– By-laws and business protocols.
		– Steering and oversight committees, including consumer and stakeholder members.
		
		Organizational needs assessment (strengths, weaknesses, opportunities, barriers) for administrative, care management, IT and financial management tools and competencies to carry out managed long-term care, including:
		– Strategies to learn management techniques.
		– Identification of essential IT and competencies.
		– A claims payment / business system adequate for
		  – Encounter reporting
		  – Service authorization and benefit coordination
		  – Utilization management
		  – Fiscal monitoring analysis
		  – Managing enrollment
		  – Provider network monitoring and contracting

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 1 – READINESS TEMPLATE

DDES Management Planning Tool For LTC Expansion "Readiness Template"

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Information/ Knowledge Management	An information management plan that supports each business process's specific information management and information technology (IT) needs.	Identification of essential IT and reporting tools and competencies to carry out managed long-term care Plan for control of data: – Data governance – Documentation – Data integration rules, – data security – Data retention – Policies and procedures for disaster recovery. – Current and future HIPAA/HIT requirements
Budgeting and Projections	Initial 3-year budget approved as part of business plan.	Data collection and analysis to support the budgeting process.
Managing Enrollment	Approved Access Plan. ADRC and ES readiness requirements are documented separately.	Participate in Access Plan development with ADRC and ES. CMO enrollment processes in place to accept new enrollments, assign care teams, make sure needed services are in place on day of enrollment, develop initial care plan w/in 10 days. (FC)
Managing Enrollment and Capitation	Policies and procedures to manage enrollment and capitation developed prior to implementation.	Reconcile enrollment reports and capitation payments with member enrollment, disenrollment and LOC effective dates. Process for resolving discrepancies. Recertification processes in place to maintain enrollee eligibility – functional screens, interface with ES. Management of cost share receivables, process for interventions if cost share payments not timely, process to refer for loss of eligibility if interventions are not successful.

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 1 – READINESS TEMPLATE

DDES Management Planning Tool For LTC Expansion "Readiness Template"

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Care Management and Care Planning --- Service Authorization --- Utilization Management	Adequate and trained care management teams in place. Approved Service Authorization Policy (RAD) in place (dif. for FC / WPP). Policies and procedures for SDS in place. Appropriate interdisciplinary plans for benefit package provided are in place.	Strategy and timeline to achieve employed and/or subcontracted IDTs. – Training in the needs of the target groups, service authorization policies and utilization management, care management techniques including outcome assessment, risk management and negotiation skills. – Training plan developed and in place. Process for prior authorization of services, clerical support and integration with fiscal systems.
Member Grievances and Appeals Process	Policies and procedures and MCO structure in place.	
Service Provision --- Provider Network --- Contract Management --- Provider Relations	State review and certification of adequacy of service capacity prior to implementation. Process for determining future provider network needs is in place. Have negotiated and executed cost-effective provider contracts.	Identification of service needs among potential enrollees, assessment of the capacity of the local provider pool to meet these needs (gap analysis); planning with potential providers to achieve a satisfactory workforce and provider pool in regard to capacity, quality and options for consumers; and establishment of minimum provider competencies. This planning must address the needs of consumers who are interested in self-directed supports. Develop contracts and put in place (contract language must be approved by DHFS). Train providers in philosophy of managed LTC, claims processes, etc. Process to ensure an adequate number of personnel with the appropriate skills to meet the scope of services, including policies to ensure services do not decline during personnel shortages due to operational contingencies or changes in staffing structure or mix. Provider capacity monitoring and management.

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 1 – READINESS TEMPLATE

DDES Management Planning Tool For LTC Expansion "Readiness Template"

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Claims Processing	Demonstrated ability to submit acceptable encounter data. Policies and procedures to handle provider appeals.	Acquire or develop claims processing capacity. Considerations include: – Customer Service functions, – Customized Check/EOB printing – Communications with members – Reporting requirements, – QA/audit, – High cost $ claim procedures, – Cost containment procedures, – Coordination of benefits – Processes for adjustments, corrections, and claims that cannot be adjudicated – Reconciliation with service authorizations – Encounter submissions, tie-outs
Financial Management and Reporting	Full-time, qualified fiscal manager (working on definition of "qualified"). Ability to manage and effectively utilize sophisticated information systems. Accounting policies and procedures in place, including for use of GAAP accrual accounting practices. Cost allocation plan. IBNR model developed (and approved by state? Certified by actuary?). Ability to produce financial statements that tie out to claims.	Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable. Cost allocation: Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies). IBNR methodology; process to monitor accuracy and reliability of the methodology. Procedures for monitoring consumer cost sharing collections. Methodology for analyzing (fiscal) risk. Monitor and analyze budget versus actual variances. Process to identify "outliers" (members whose claims exceed expected costs). Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable. Maintenance of solvency protections. Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies). Develop and test IBNR methodology; process to monitor accuracy and reliability of the methodology.

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 1 – READINESS TEMPLATE

DDES Management Planning Tool For LTC Expansion "Readiness Template"

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Utilization Review	Demonstrated ability to produce reports that clearly communicate utilization information and trends to all levels of the MCO. Process by which utilization information will be shared with IDTs and other parts of the MCO, and how IDTs and others will be given help in analyzing that information.	Process for reconciliation and reporting on services authorized versus services used; service utilization reports. Process to communicate changes in practice patterns and health care delivery identified through utilization management reviews. Process to review and evaluate high volume / high risk indicators, practice guidelines and protocols, unusual occurrences, clinical outcomes, and services provided. How are these reviews used to minimize risk?
Quality Management	QM organizational structure, including: – A senior manager with resource-deployment authority is designated as responsible for QM program. – A full time qualified professional is in place to coordinate the quality program. – QM activities have individuals or units with clearly assigned responsibility for them. – Mechanisms for active participation from consumers, staff, and others. – Must have clear operational links to and support from other functional areas. DHFS- approved Quality Program/Plan, adopted by gov. board, including: – Includes annual goals based on findings from previous QM activities; – Describes quality-monitoring processes and activities; – Describes at least one performance improvement project.	Design QM program that will: – Assure quality of both provided and purchased services; – Monitor performance and Detect problems; – Determine causes of problems; – Prioritize quality-improvement activities; – Determine effective remediation; – Follow up to verify problems are fixed; and – Carry out improvement efforts even in absence of identified problems. MCO ensures that assessments and care plans are timely and of high-quality—without checking or prior approval from DHFS. MCO determines, documents, and reports its own performance (e.g., immunization rates) MCO plans and carries out tightly focused improvement projects.

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 2 – ELIGIBILITY FOR MANAGED LONG-TERM CARE

A2.1 Eligibility for the Family Care benefit

A2.1.1 General conditions of eligibility

(a) *Age*. The person will attain at least the age of 18 years during the application month.
(b) *Residency*. The person is a resident of a county in which the managed long-term care benefit is available through a managed care organization.
(c) *Target group*. The person has a physical disability, a developmental disability or infirmities of aging.
(d) *Cost sharing*. The person pays any cost sharing obligations required as a condition of post eligibility treatment of income.
(e) *Other non–financial conditions*. The person meets the nonfinancial conditions of eligibility for medical assistance under s. HFS 103.03 (2) to (9).
(f) *Divestment*. The person is not currently ineligible for medical assistance under the provisions of ss. 49.453 and 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 because he or she divested assets.

A2.1.2 Functional eligibility

The person has a long–term or irreversible condition and meets one of the following comprehensive or intermediate level of care requirements or grandfathering requirements:

1. *Comprehensive functional capacity level*. A person is functionally eligible at the comprehensive level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screen:
    a. The person cannot safely or appropriately perform 3 or more activities of daily living.
    b. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living.
    c. The person cannot safely or appropriately perform 5 or more IADLs.
    d. The person cannot safely or appropriately perform one or more ADL and 3 or more IADLs and has cognitive impairment.
    e. The person cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment.
    f. The person has a complicating condition that limits the person's ability to independently meet his or her needs as evidenced by meeting both of the following conditions:
        1) The person requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range of medical or social interventions due to a multiplicity of conditions.
        2) The person has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.
2. *Intermediate functional capacity level*. A person is functionally eligible at the intermediate level if the person is at risk of losing his or her independence or functional capacity unless he

or she receives assistance from others, as is evidenced by a finding from application of the functional screen that the person needs assistance to safely or appropriately perform either of the following:

a. One or more ADL.
b. One or more of the following critical IADLs:
    3) Management of medications and treatments.
    4) Meal preparation and nutrition.
    5) Money management.

3. *Grandfathering*. If a person is not eligible at either the comprehensive or intermediate levels, the department shall deem the person functionally eligible for the managed long-term care benefit if all of the following apply:
    a. The person has a long–term or irreversible condition.
    b. The person is in need of services included in the managed long-term care benefit.
    c. The person first applies within 36 months after the date on which the managed long-term care benefit is initially available in the person's county residence.
    d. On the date that the family care benefit became available in the county of the person's residence, he or she was a resident in a nursing home or had been receiving for at least 60 days, under a written plan of care, long–term care services that were funded under any of the following:
        1) The long–term support community options program under s. 46.27, Stats..
        2) Any home and community–based waiver program under 42 USC 1396n (c), including the community integration program under s. 46.275, 46.277 or 46.278, Stats.
        3) The Alzheimer's family caregiver support program under s. 46.87, Stats.
        4) Community aids under s. 46.40, Stats., if documented by the county under a method prescribed by the department.
        5) County funding, if documented under a method prescribed by the department.

A2.1.3 Financial eligibility

The person is eligible for medical assistance under ch. 49, Stats., and chs. HFS 101 to 108. There is currently limited funding for individuals not eligible for Medicaid in Family Care, with a freeze on most new enrollments. For more information about non-Medicaid eligibility for Family Care, see a memorandum titled "Freeze on Enrollments of New Persons Not Eligible for Medical Assistance" at: http://dhfs.wisconsin.gov/LTCare/Partners/PDFs/Non-MAFreezeMemo7-31-03.pdf

A2.2 Eligibility for the Wisconsin Partnership Program benefit

A2.2.1 Acceptance of the WPP MCO managed Medicare benefit

For a person who is eligible for Medicare, the person must accept managed Medicare benefits from the Partnership MCO in order to be eligible to enroll in the Partnership MCO to receive the Medicaid managed long-term care benefit.

A2.2.2 General conditions of eligibility

(a) *Age*. The person will attain at least the age of 18 years during the application month.

(b) *Residency*. The person is a resident of a county in which the managed long-term care benefit is available through a managed care organization.
(c) *Target group*. The person has a physical disability, a developmental disability or infirmities of aging.
(d) *Cost sharing*. The person pays any cost sharing obligations required as a condition of post eligibility treatment of income.
(e) *Other non–financial conditions*. The person meets the nonfinancial conditions of eligibility for medical assistance under s. HFS 103.03 (2) to (9).
(f) *Divestment*. The person is not currently ineligible for medical assistance under the provisions of ss. 49.453 and 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 because he or she divested assets.

A2.2.3 Functional eligibility

The person has a nursing facility level of care as documented on the long-term care functional screen.

A2.2.4 Financial eligibility

The person is eligible for medical assistance under ch. 49, Stats., and chs. HFS 101 to 108.